

**ERIE COUNTY LICENSED HOUSING APPLICATION
COVER SHEET**

Applicant's Name: _____ ***Date Completed:** _____

Check The Type of Housing the Consumer Is Interested In. See page 2 for housing descriptions.

<input type="checkbox"/> Supervised CR (SCR & SOCR)	<input type="checkbox"/> Supervised Senior CR (SSCR)	<input type="checkbox"/> Treatment/Supervised Apt. (TSA)
<input type="checkbox"/> Young Adult Housing (YAH)	<input type="checkbox"/> Residential Care Center (RCCA)	<input type="checkbox"/> Family Care (FC)
<input type="checkbox"/> SRO (SRO)	<input type="checkbox"/> Adult Home (AH)	<input type="checkbox"/> MICA Housing (MICA)

**Supported Housing Applicants must complete a separate application and submit directly to the Erie County Housing Coordinator*

Please Check Each Housing Provider Applied To

() Buffalo Federation of Neighborhood Centers 97 Lemon St. Buffalo, New York 14202 Telephone: 852-5065 fax: 852-6270 SCR - TSA	() DePaul Community Services 2240 Old Union Road, Cheektowaga, New York 14227 Telephone: 608-1000 fax: 608-0131 SCR - TSA	() McKinley Sq. or Kensington Sq. Forward Referral Information to: DePaul Community Services 2240 Old Union Road, Cheektowaga, New York 14227 Telephone: 608-1000 fax: 608-0131 SRO
() Transitional Services, Inc. 389 Elmwood Ave, Buffalo, New York 14222 Telephone: 874-8190 fax: 874-4429 SCR-SSCR-TSA-YAH-MICA-AHS	() Greenwood Residences, Inc. 660 Mineral Springs Rd. West Seneca, New York 14224 Telephone - 827-4060 fax: 827-4063 SSCR	() Southern Tier Environments for Living, Inc. 715 Central Avenue Dunkirk, New York 14048 Telephone: 366-3200 fax: 366-7840 SCR - TSA - SRO - SSCR
() Waterfront Residence 2 Duquesne, Celeron, New York 14720 Telephone: 664-4313 fax: 488-1193 MICA	() Cudmore Heights 400 Forest Avenue, Buffalo, New York 14222 Telephone: 816-2392 fax: 816-2551 RCCA	() CMI - Choices 1570 Buffalo Ave. Niagara Falls, New York 14303 Telephone: 285-3425 fax: 285-5908 SCR-TSA
() Olmstead Residence 3 Rees Street, Buffalo, New York 14213 Telephone: 884-3445 fax: 885-3044 SCR	() Pathways Residence P.O. Box 389, Collins, New York 14034 Telephone: 532-5854 fax: 532-6258 SCR	() BPC - Family Care 400 Forest Avenue, Buffalo, New York 14222 Telephone: 885-2261 fax: 816-2951 FC

Self Referrals Welcomed

Contact The Mental Health Peer Connection if You Need Assistance
836-0822

Forward a completed form to each agency checked on this page. Admission decisions are determined within 30 days of receiving a **complete** referral package. **In accordance with federal, state and municipal fair housing laws no person shall be denied housing because of his/her race, color, religion, national origin, sex, marital status, age, disability, familial status, sexual orientation or income.**

ERIE COUNTY LICENSED HOUSING APPLICATION

Descriptions of Licensed Housing Programs

LICENSED HOUSING

Supervised Community Residences - SCR & SOCR are congregate care facilities (group homes) which house 8 to 24 residents 18 years of age or older. These Programs are considered transitional and rehabilitative in nature, as the resident's goal is to move to a less restrictive living environment within 24 months. Bedrooms are often shared but some programs have single bedrooms. Residents participate in the upkeep of the house which includes meal planning and preparation. Recreation activities are provided. Some group homes include an attached training apartment (TSI) for residents ready to test independent living skills. Staff is on site 24/7. SCR services are provided by The Buffalo Federation of Neighborhood Centers, DePaul Community Services, Southern Tier Environments for Living, Transitional Services, Inc., CMI and the Olmstead (SOCR)* and Pathways Residences (SOCR).

*State Operated Community Residence (BPC)

Supervised Senior Community Residences - SSCR operate the same as Supervised Community Residences but are for consumers who are 55 years of age or older. Residences are encouraged to identify independent living goals but there is less emphasis placed on moving to an apartment. SSCR are provided by Greenwood Residences (all single bedrooms), Southern Tier Living Environments and Transitional Services, Inc.

Treatment/Supervised Apartments - TSA provide transitional housing in shared one, two and three bedroom apartments in the community. The apartments are either located at a single site which has staff on site 24/7 or scattered site apartments which staff visit from 3 to 7 days each week and are on call for emergencies 24/7. Staff provide services designed to assist residents obtain or refine skills necessary for independent living. Cash allowances for groceries and clothing are provided by some programs. Residents are expected to develop individual goals which focus on living more independently. The typical length of stay is 18 to 24 months. TSA housing services are provided by The Buffalo Federation of Neighborhood Centers, DePaul Community Services, Southern Tier Environments for Living, CMI and Transitional Services, Inc.

MICA Housing - MICA - are Group Home and Treatment Apartment Programs capable of providing specialized staffing and services for consumers who are diagnosed with an addictions disorder as well as a psychiatric disability. MICA Group Homes are operated by Transitional Services, Inc. and the Waterfront Residence (BPC). Transitional Services, Inc. also operates a 10 bed supervised apartment program for MICA. Single bedrooms are available.

Young Adult Housing - YAH is a group home and supported housing program providing specialized services for individuals 18 to 21 years of age who are transitioning from Residential Treatment Facilities or congregate living environments for adolescents. Services are similar to other group settings. There is staffing capacity to provide more intensive services for individuals participating in the supported housing component of the program. YAH services are provided by Transitional Services, Inc.

Residential Care Centers for Adults - RCCA offers congregate care support facilities for transitional and extended stays for up to 101 residents. While it is anticipated that, over time, residents will move to more independent housing, there is no set time for completing the program. RCCA's are designed to work with individuals who need more focused ADL skills training and other rehabilitative services. Staff are on site 24/7, and nursing staff is available 5 days a week. The RCCA is operated by BPC.

Family Care - FC provides housing for up to four adults with an unrelated family in the community. Providers offer support, furnished rooms, meals, companionship and security. The host family also provides 24-hour supervision, laundry, housekeeping and medication management services. The Family Care Program is operated by BPC.

Single Room Occupancy - SRO's provide housing that is specifically designed to offer permanent housing in a service-enriched setting. These programs are intended to provide housing and services for individuals capable of living independently. A social service team provides services on-site which includes case management, interactive groups, activities, medication management, money management and vocational linkage. SRO housing is provided by DePaul Community Services.

Adult Home - AH's are staffed 24/7 by professionals who work collaboratively with each resident and their service provider. Adult Homes are licensed to provide long term residential care, meals, medication monitoring, structured and recreational activities and individualized ADL instruction. Each resident is provided their own room. The Adult Home Program is operated by the YWCA.

For Housing Provider Use Only

Date Rec'd _____

Disposition _____

I. APPLICANT DATA

*Name: _____ *Social Security Number: _____
(Last) (First) (Middle)

*Current Address: _____ *Telephone #: _____
(Street)

(City) (State) (Zip Code)

*Months in current living situation _____

Previous Address: _____ *County: ☐ Erie ☐ Other _____

*Date of Birth: ____/____/____ *Sex: ____ *Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Religion (optional): _____ *Race (optional): _____

*Highest Level of Education Completed: _____ Literate: ☐ Yes ☐ No

*Family Contact: _____ Relationship: _____

Address: _____ Telephone #: _____

***II. DIAGNOSIS (DSM IV Code)**

AXIS I _____ AXIS I _____

AXIS II _____ AXIS II _____

AXIS III _____

AXIS IV (a) Stressor _____ (b) Severity _____ (c) Duration _____

AXIS V (a) Current GAF Score _____ Past Year GAF Score _____ (if available)

(ENTER TWO DIGIT SCORES FROM 01-90)

Intellectual Level: (IQ) _____ Below 70 _____ 70-84 _____ Above 84

***III. REFERRED BY**

Name: _____ Telephone Number: _____

Agency: _____

Program: _____ Contact (if other than above): _____

Address: _____

Applicant's Name: _____

IV. RISK ASSESSMENT

Is the consumer identified as high-risk, high-need due to any one of the following characteristics?

YES NO DON'T KNOW

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A history of sexually abusing others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A history of fire setting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A history of indiscriminate serious assault (consumer arrested and/or victim required medical attention)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A history of homicide
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A history of suicide attempts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A history of repeated episodes of serious self-harm requiring medical attention
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Three episodes of loss of housing in the last 12 months
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical needs that cannot be addressed by the housing provider
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of alcohol abuse/dependence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of substance abuse/dependence (if yes, note below: onset and frequency of use, type of substance, date of last use and method of administration)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of arrests and dispositions (i.e. currently in jail or facing charges, released from jail or prison within the last year, probation/parole supervision, CPL 330.20, Alternative to incarceration, etc.)

If you answered yes to any of the above, please provide details in the space provided below or include in a psychosocial history: _____

Describe Signs of Decompensation and/or Prodromal Symptoms: _____

V. FUNCTIONAL STRENGTHS AND DEFICITS

Does Applicant Currently:

	<u>Independently</u>	<u>Needs Help</u>	<u>Unable</u>	<u>Unknown</u>
➤ Manage personal needs (grooming/hygiene/laundry)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Budget Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Respond appropriately to emergency situations (e.g. fire, first aid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Comply with medication regimen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Use public transportation and other community resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Plan menus, grocery shop, prepare meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Self-Medicate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VI. Please attach copies of most recent progress notes, Service Plan Reviews and Psychiatric evaluations or psychosocial history (see outline).

Applicant's Name: _____

***VII. SOURCES OF INCOME/FINANCIAL RESPONSIBILITIES**

Please Check All That Apply

☐ **No Assets or Funding Source**

☐ **Public Assistance**

☐ Active Monthly Amount \$ _____ County _____ Telephone # _____
☐ Pending Application Date _____ Case Worker _____

☐ **Supplemental Security Income (SSI)**

☐ Active Monthly Amount \$ _____ County _____ Telephone # _____
☐ Pending Application Date _____ Overpayment? _____ SSI Worker _____

☐ **Social Security (SSD or SSA)**

☐ Active Monthly Amount \$ _____ Type of Benefit (i.e. Disability) _____ Claim # _____
☐ Previously Recd./Inactive ☐ Pending Application Date _____ Type Applied For _____

***Payee Status** ☐ Self
☐ Representative

Payee _____
Name _____ Telephone _____
Street _____ City/State _____ Zip Code _____

☐ **Wages** (Include Sheltered Workshop) ☐ Full Time ☐ Part Time
Employer _____ Wages \$ _____ per week

☐ **Union Benefits** \$ _____ / month

☐ **Unemployment Insurance Benefits** \$ _____ / month

☐ **New York State Disability** \$ _____ / month

☐ **Railroad Retirement Benefits** \$ _____ / month

☐ **Workers Compensation Benefits** \$ _____ / month

☐ **Pensions/Annuity** \$ _____ / month

☐ **Veterans Benefits** \$ _____ / month

☐ **Family Support** (Child & Adolescent Referrals **Only**) Wage Earner's Gross Income \$ _____ /Year

Other Assets:

☐ Alimony/Child Support Received \$ _____ / month

☐ Home Owner

☐ Bank Account(s) - List Banks

☐ Stocks ☐ Bonds ☐ Trusts ☐ Burial Fund ☐ Motor Vehicle ☐ Life Insurance

Food Stamps

☐ Active Amount \$ _____ /Month ☐ Pending Application Date _____

Health Insurance

☐ Medicaid # _____ Access # _____ Seq.# _____

☐ Medicare # _____

☐ Other Type _____ Policy # _____

FINANCIAL RESPONSIBILITIES (Include Monthly Amounts)

☐ No Known Financial Responsibilities ☐ Student Loans \$ _____ Medical Expenses \$ _____

☐ Alimony/Child Support \$ _____ ☐ Motor Vehicle \$ _____ ☐ Other _____

Applicant's Name: _____

***VIII. PREVIOUS RESIDENTIAL SERVICES**

<u>AGENCY</u>	<u>ADMISSION DATE</u>	<u>DISCHARGE DATE</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

***IX. PREVIOUS PSYCHIATRIC HOSPITALIZATIONS / INSTITUTIONALIZATIONS**

(Include inpatient rehabilitation for substance abuse. Attach discharge summaries as available. Use other attachments if needed.)

<u>FACILITY</u>	<u>SERVICE (i.e., detox)</u>	<u>ADMISSION DATE</u>	<u>DISCHARGE DATE</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ER VISITS (list dates over last 6 months) _____

***X. PREVIOUS OUTPATIENT TREATMENT / CASE MANAGEMENT SERVICES (within the past 6 months)**

<u>AGENCY</u>	<u>TYPE OF SERVICE</u>	<u>ADMISSION DATE</u>	<u>DISCHARGE DATE</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

***XI. CURRENT OUTPATIENT TREATMENT**

Agency _____ Address _____ Contact _____
Telephone _____ Date Linkage Completed _____
Prescribing Psychiatrist _____ Telephone #: _____

***XII. CURRENT CARE COORDINATION/CASE MANAGEMENT**

☐ None ☐ ACT ☐ ICM ☐ TCM ☐ SCM ☐ Other Case Manager

☐ Active Agency _____
Case Manager's Name _____ Telephone # _____

☐ Pending - Referral has been made.

☐ Assisted Outpatient Treatment (A.O.T.)

Applicant's Name: _____

MEDICATION	DOSAGE	FREQUENCY

***XIII. CURRENT COMMUNITY REHABILITATION AND SUPPORTS**

(If an activity or support is pending or recommended, please note under comments.)

<input type="checkbox"/> IPRT	Agency _____	Contact _____	Tel. # _____
<input type="checkbox"/> Work	Agency _____	Contact _____	Tel. # _____
<input type="checkbox"/> C.D.T.	Agency _____	Contact _____	Tel. # _____
<input type="checkbox"/> P.R.O.S	Agency _____	Contact _____	Tel. # _____
<input type="checkbox"/> Peer Services	Agency _____	Contact _____	Tel. # _____
<input type="checkbox"/> Self-Help Groups	Agency _____	Contact _____	Tel. # _____
<input type="checkbox"/> Social Clubs	Agency _____	Contact _____	Tel. # _____
<input type="checkbox"/> Clubhouses	Agency _____	Contact _____	Tel. # _____
<input type="checkbox"/> School	Agency _____	Contact _____	Tel. # _____

Please note days and hours of activities below:

Comments:

Other Social Supports: ☐ Family ☐ Job ☐ Other _____

*Transportation Access: ☐ Public ☐ Own Car ☐ Program Van ☐ Family ☐ Medicaid Cab

***XIV. CURRENT HEALTH CARE PROVIDER**

Clinic _____ Contact _____ Tel. # _____

Address _____

Primary Care Physician _____

*Advanced Directive ☐ Yes ☐ No

Contact Person: _____ Phone number: _____

Applicant's Name: _____

XV. MEDICAL EXAMINATION

Date of most recent medical examination: _____

(Completed by a Physician, Nurse Practitioner or Physician's Assistant)

A current (within 12 months) and legible history and physical examination may be substituted for the information requested below.

Please check ALL that are current or historic medical concerns If yes, please comment.

	Unknown	No	Yes	Comments
Allergies/Medication Sensitivity	_____	_____	_____	_____
Arteriosclerosis	_____	_____	_____	_____
Communicable diseases	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Hearing Impairment	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____
History of Cancer	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____
Incontinency	_____	_____	_____	_____
Lung Disease	_____	_____	_____	_____
Mobility Limitations	_____	_____	_____	_____
Podiatry	_____	_____	_____	_____
Seizure Disorder	_____	_____	_____	_____
Skin Condition(s)	_____	_____	_____	_____
Special Diet(s)	_____	_____	_____	_____
Speech Impairment	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____
Visual Impairment	_____	_____	_____	_____

Other (Please Specify)

For any of the above conditions checked YES, please indicate specific instructions to be followed by the applicant.

Signature and title of person completing this form: _____

Date: _____

Applicant's Name: _____

XVI. TUBERCULOSIS TEST RESULTS (To be completed by a Nurse, Nurse Practitioner, Physician or Physician's Assistant)

It is necessary that all applicants be screened for tuberculosis within *one year* of the referral. The following documentation is required. Medical records verifying administration of the PPD test may be submitted in lieu of this form.

Date of PPD (Mantoux) Test: _____

PPD (Mantoux) Test Administered by: _____

Results of PPD (Mantoux) Test: _____ Negative _____ Positive

Date of Chest X-Ray (if indicated): _____

Results of Chest X-Ray: _____ Negative _____ Positive

Signature and credentials of person completing this form: _____

Date: _____

XVII. PHYSICIAN AUTHORIZATION FOR REHABILITATION SERVICES OF COMMUNITY RESIDENCES

APPLICANT'S NAME: _____

APPLICANT'S MEDICAID NUMBER: _____

ICD.9 DIAGNOSIS: _____
(Please enter code and description) 5 Digit Code

I, the undersigned licensed physician, based on clinical information and my face to face assessment of this client, have determined that _____ meets one of the following criteria (A, B, C or D) for severe and persistent mental illness (SPMI). (Client's Name)

_____ **A. The individual is currently enrolled in SSI or SSDI due to a designated mental illness.**

_____ **B. Extended Impairment in Functioning due to Mental Illness -**

The individual has experienced two of the following four functional limitations due to a designated mental illness over the past twelve months on a continuous or intermittent basis:

_____ **Marked difficulty in self-care** (personal hygiene; diet; clothing; avoiding injuries; securing health care or complying with medical advice).

_____ **Marked restriction of activities of daily living** (maintaining a residence; using transportation; day-to-day money management; accessing community services).

_____ **Marked difficulties in maintaining social functioning** (establishing and maintaining social relationships; interpersonal interactions with primary partner, children, other family members, friends or neighbors; social skills; compliance with social norms; appropriate use of leisure time).

_____ **Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings** (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings; individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks.)

_____ **C. The individual has met criteria for ratings of 50 or less on the Global Assessment of Functioning Scale** (Axis V of DSM-IV) due to a designated Mental Illness over the past twelve months on a continuous or intermittent basis.

_____ **D. Reliance on Psychiatric Treatment, Rehabilitation and Supports.**

A documented history shows that the individual at some prior time, met the threshold for items B or C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder, e.g., hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

The client would benefit from the provision of mental health Community Rehabilitation Services within a Community Residence Program defined pursuant to Part 593 of 14 NYCRR (see reverse side). This determination is in effect for the period from _____ to _____ at which time there will be an evaluation for continued stay.

_____ Month/Day/Year	_____ MD Name (please print)	_____ Licensure #
	_____ MD Signature	_____ Medicaid License #

_____ Check here if client is enrolled in Managed Care (e.g., an HMO or Managed Care Coordinated Program) and enter primary care physician name and managed care provider identification number.

Managed Care Physician

Managed Care Provider ID #

COMMUNITY REHABILITATION SERVICES NOTATION CODES

- AT - Assertiveness/Self Advocacy Training** - Training which promotes the individual's ability to assess his or her needs to make a life status change and to increase self-awareness about his or her values and preferences. Training is intended to increase an individual's ability to respond to medical, safety and other personal problems. Activities are also intended to improve communication skills and facilitate appropriate interpersonal behavior.
- CI - Community Integration Services/Resource Development** - Activities designed to help individuals to identify skills and community supports necessary for specific environments; to assess their skill strengths and deficits in relationship to environmental demands; to assess resources available to help the individual; to develop a natural support system; by accessing social, educational and recreational opportunities.
- DLS- Daily Living Skills Training** - Activities which focus on the acquisition of skills and capabilities to maintain primary activities of daily life; services are provided by addressing areas of functioning in categories such as: dressing, personal hygiene and grooming, selection and/or preparation of food, cleaning and washing of clothes, maintenance of environment, budgeting and money management. Training is intended to increase those competencies needed by the individual to live in his or her goal environment.
- HS - Health Services** - Training to maximize independence in personal health care by increasing the individual's awareness of his or her physical health status and the resources required to maintain physical health; including regular medical and dental appointments, basic first aid skill, basic knowledge of proper nutritional habits and family planning. Also, includes training on special topics such as AIDS awareness.
- MMT-Medication Management and Training** - The storage, monitoring, record keeping and supervision associated with the self-administration of medication. This does not include prescribing, but does include a certain degree of reviewing the appropriateness of the residents' existing regimen with the appropriate physician. Activities which focus on educating residents about the role and effects of medication in treating symptoms of mental illness and training in the skill of self-medication are also included.
- PT - Parent Training** - Structured activities intended to promote positive family functioning and enable the resident to assume parenting responsibilities. Activities include peer support groups to foster skills around effective parenting, assistance in selecting and obtaining housing appropriate for families, and linkage with the children's service system. Psycho-education programs on parenting skills, single parenting issues, child care and the nature of mental illness and its effect on the family are also included.
- RC - Rehabilitation Counseling** - A therapeutic modality which includes assisting the individual in clarifying future directions and the potential to achieve rehabilitation goals; identifying and specifying behaviors that impede goal setting; improving understanding regarding the influence of environmental stress; and helping an individual to apply newly learned behaviors to housing and other situations outside the program structure.
- SD - Skill Development Services** - Activities which assist clients to gain and utilize the skills necessary to undertake employment or pursue educational opportunities. This may include skills related to securing appropriate clothing, scheduling, work related symptom management, and work readiness training.
- S - Socialization** - Activities whose purpose are to diminish tendencies toward isolation and withdrawal or overly aggressive behavior by assisting residents in the acquisition or development of social and interpersonal skills. "Socialization" is an activity whose purpose is to improve or maintain a resident's capacity for social involvement by providing opportunities for application of social skills. This occurs through resident/staff interaction in the program and through exposure with staff to opportunities in the community. Modalities used in socialization include individual and group counseling and behavior interventions.
- SAS -Substance Abuse Services** - Services provided to increase the individual's awareness of alcohol and substance abuse and reduction or elimination of its use; including verbal and medication therapies, psycho-educational approaches, and relapse prevention techniques.
- SM - Symptom Management** - Activities to achieve a maximum reduction of psychiatric symptoms and increased functioning. This includes the ongoing monitoring of residents' mental illness symptoms and response to treatment, interventions designed to help residents manage their symptoms, and assisting residents to develop coping strategies to deal with internal and external stressors. Services range from providing guidance around everyday life situations to addressing acute emotional distress through crisis management and behavior intervention techniques.

Erie County Licensed Housing Application

ERIE COUNTY LICENSED HOUSING CHECKLIST

Please utilize this checklist to ensure the Licensed Housing Referral Application is complete.

- () Licensed Housing Cover Page (page 1)
- () Licensed Housing Application Information
- () Housing Risk Assessment (page 4)
- () Criteria For Severe and Persistent Mental Illness (SPMI) Among Adults (page 5)
- () Functional Assessment Worksheet (page 6).
- () Medical and Health Information (page 7 & 8)
- () Physician Authorization for Rehabilitation Services of Community Residences (page 9 & 10)
- () Psychiatric Assessment completed within the past 12 months.
 - () Psychosocial History. *To include documentation regarding signs of decompensation and/or prodromal symptoms, risk behaviors, legal history, substance abuse, general health and personal & family history.*
- () Copy of the referral agency consent for release of information.